MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1452

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 4 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 409 N. Durham St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME WILLIAM BENN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 6, 1896

8. AGE: Years	Months	Days	If less than one day
49	7	12	hrs. min.

9. Birthplace: Madison, Georgia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: John Benn
13. Birthplace: Madison, Georgia

MOTHER
14. Maiden name: Maria Walker
15. Birthplace: Madison, Georgia

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-21-46 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cemty
Location: A. A. Co.
18. Funeral director: Williams & Jackson
Address: 916 Penna Ave

19. Feb. 18, 1946 (Date rec'd by registrar) Albert L. Bruckhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 18, 1946 at 9:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 14, 1946 to Feb. 18, 1946 and that I last saw him alive on February 18, 1946

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 12-21-45
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. (M. D. or other)
Address: Henryton, Md. Date signed: 2-18-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

0145376

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 25 yrs

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural Westminster Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Annie Cathrine Berg

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6 (b) Name of husband or wife Charles W. Berg

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9 1861

8. AGE:

Years	Months	Days	If less than one day
84	5	2	hrs. min.

9. Birthplace md. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Jacob Kaufman

13. Birthplace md.

MOTHER 14. Maiden name Sarah Benner

15. Birthplace md.

16. Informant Edward Kaufman

Address Westminster, Md.

17. Burial Date thereof Feb. 14, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bridge

Location Westminster, Md.

18. Funeral director J. H. Bankard Son

Address Westminster, Md.

19. 2/12 1946 H. L. Woodward

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1946, at 10:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1940, to Feb. 11, 1946, and that I last saw h[illegible] alive on Feb 11 1946.

	DURATION
Immediate cause of death: Myocardial degeneration	1 yr +
Due to: Diabetes	6+ yrs.
Due to:	
Other conditions: Valvular heart disease (not severe)	5 yrs

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Reese Wilkens M. D. or other

Address Westminster Md. Date signed 2/12/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01454

Reg. Dist. No. 81

1. PLACE OF DEATH:
County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mack Sherman Biggus

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Hattie Biggus
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1871

8. AGE: Years: 74 | Months: -- | Days: -- | If less than one day: hrs. min.

9. Birthplace: Frederick County Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farming

FATHER
12. Name: Soloman Biggus
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rachel L White
15. Birthplace: Maryland

16. Informant: Mrs Hallie Hoy
Address: Frederick Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 21-1946 (month) (day) (year)
Cemetery or crematory: Old Fields Cemetery
Location: near Libertytown Md

18. Funeral director: D.D.Hartzler & Sons
Address: Union Bridge & New Windsor Md

19. Feb 20, 1946 (Date rec'd by registrar) — Registrar: E Eichman, Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 19, 1946, at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1, 1946, to Feb 19, 1946 and that I last saw h.. living alive on Feb. 17, 1946

Immediate cause of death: Chronic Myocarditis — DURATION

Due to:

Due to: Arteriosclerosis

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. H. Legg, M. D. or other
Address: Union Bridge, Md. Date signed: 2-20-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

01455 77

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Hampstead Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Hour.

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(If or newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Hampstead Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Carroll Lane

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Dennis Bowman Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): —

8. AGE: Years — Months — Days — If less than one day: 1 hrs. 0 min.

9. Birthplace: Hampstead Md (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER 12. Name: Charles Dennis Bowman Sr.

FATHER 13. Birthplace: Wesley Chapel Md

MOTHER 14. Maiden name: Vera Margaret Mancha

MOTHER 15. Birthplace: Freeingmount Md

16. Informant: Mrs Charles Bowman

Address: Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 10-46 (month) (day) (year)

Cemetery or crematory: Wesley

Location: Cunall Rd

18. Funeral director: Edw A Tipton

Address: Hampstead Md

19. Feb 10 1946 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 9 1946, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 9 1946 to Feb 9 1946

and that I last saw him alive on 1 P.M. 1946

Immediate cause of death: Prematurity — DURATION: 6 mo.

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: Joseph E. Bunch M.D. (M. D. or other)

Address: Hampstead Md Date signed: 2-9-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-P)

01456

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs., 5 mos., 14 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium, Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 221 Forrest Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MILLER BROWN

3.(b) Social Security Number: 214-10-6849

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 16, 1907

8. AGE: Years	Months	Days	If less than one day
38	6	17	hrs. min.

9. Birthplace: Darthington, S.C. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Robert Brown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 7-1946 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location:
18. Funeral director: Elroy O. Wilson
Address: 000 Brantly Ave

19. Feb. 3, 1946 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 3, 1946 at 4:20P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19, 1942, to Feb. 3, 1946 and that I last saw him alive on February 3, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1939
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 2-3-46

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

01457

Reg. Dist. No. 75

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Lenard Burkheimer

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Sarah Burkheimer (deceased)
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Aug. 23, 1857
8. AGE: Years: 88 Months: 6 Days: 14 If less than one day: hrs. min.
9. Birthplace: Maryland Carroll Co. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Henry Burkheimer
13. Birthplace: Germany
MOTHER 14. Maiden name: Wilhelmina Schlegle
15. Birthplace: Baltimore - Md.
16. Informant: Cora Burkheimer
Address: Manchester Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-10-46 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester Md
18. Funeral director: Jacob Wm's Sons
Address: Manchester. Md
19. Feb. 8 1946 (Date rec'd by registrar) Mrs. W. R. S. Denver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 7 1946 at 2:30 a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1936 to Feb. 7 1946
and that I last saw him alive on Feb. 7 1946

	DURATION
Immediate cause of death: Coronary Thrombosis	1 hr.
Due to: Arteriosclerotic Heart disease	8-10 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Maurice C. Partinfield M. D. or other
Address: Sampsteen Md Date signed: 2-8-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01458

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Mo. 24 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Camp Parole
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: WILLIAM COLLINS CHAMBERS

3.(b) Social Security Number: 220-16-4830

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	COLORED	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 25, 1903

8. AGE:	Years	Months	Days	If less than one day
	42	6	22	..... hrs. ..... min.

9. Birthplace: Galesville, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Richard Collins

13. Birthplace: Edgewater, Md.

MOTHER — 14. Maiden name: Marilyn Chambers

15. Birthplace: Galesville, Md.

16. Informant: Reuben Hoffman

Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/19/46 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: Annapolis

18. Funeral director: J. B. Johnson

Address: Annapolis

19. Feb. 16, 1946 (Date rec'd by registrar) Albert R. Swarthout Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 16, 1946 at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23, 1946, to Feb. 16, 1946 and that I last saw him alive on Feb. 16, 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Feb. 5, 1944
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Reuben W. Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 2/16/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01459

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 159 W. Henrietta Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MARY CUNNINGHAM

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 5, 1929

8. AGE:	Years	Months	Days	If less than one day
	16	10	29	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Calvert Parker
13. Birthplace: Unknown

MOTHER
14. Maiden name: Annie ?
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2 - 6 - 46 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Baltimore Md.

18. Funeral director: [illegible]
Address: 108 W Montgomery St

19. Feb. 4, 1946 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 4, 1946, at 2:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 23, 1946, to Feb. 4, 1946 and that I last saw her alive on February 4, 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Dec. 1, 1945
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 2-4-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

01460

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 8 mos., 19 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 1 yr., 8 mos., 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. Bayside Drive Inverness
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Matilda L. Ehinger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William Ehinger (deceased)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 5/31/1880

8. AGE: Years	Months	Days	If less than one day
65	8	19	..... hrs. ..... min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name William Snyder
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Catherine E. Hoover
15. Birthplace Pennsylvania

16. Informant History record, Springfield State Hospital
Address Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-21-46 (month) (day) (year)
Cemetery or crematory Oak Lawn Cem.
Location Balto. Md.

18. Funeral director Harry A. Whitaker
Address 4101 Edmondson Ave.

19. Feb. 19 1946 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1946, at 12 25 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31 1944, to February 19 1946 and that I last saw h[illegible] alive on February 19 1946

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to Hemiplegia	2 weeks
Due to	
Other conditions Chronic Myocarditis	unknown
Involutional psychosis, Paranoid type	6 years

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Arnold K. Eichert, M.D.
M. D. or other
Address Springfield State Hosp. Sykesville Md. Date signed 2-19-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01461

CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH:
County: Carroll
City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Mt. Airy.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: FANNIE W. FRITZ

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Francis D. Fritz deceased
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Aug. 12, 1862
8. AGE: Years: 83 Months: 5 Days: 29 If less than one day: hrs. min.
9. Birthplace: Frederick Co. Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: Silas Rippeon
13. Birthplace: Maryland
MOTHER 14. Maiden name: Mary J. Rippeon
15. Birthplace: Maryland
16. Informant: Mrs. Carroll Burdette
Address: Mt. Airy, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-14-46 (month) (day) (year)
Cemetery or crematory: Fair mount
Location: Liberty Town, Frederick Co. Md.
18. Funeral director: C. M. Waltz
Address: Winfield, Md.
19. Feb. 13 1946 (Date rec'd by registrar) Thos D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 11 1946, at 6.55 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 3 1946, to Feb 11 1946
and that I last saw h.er alive on Feb 11 1946
Immediate cause of death: Cerebral Hemorrhage — DURATION: 3 dys
Due to: Hypertension — 8 years
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?
23. SIGNATURE: C M Kay Poole M. D. or other
Address: Mt Airy Md Date signed: 2/12/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change in age is shown on FILM No. I 04 MAY 28 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

01462

Reg. Dist. No. 82

1. PLACE OF DEATH:
County Carroll
City or town Mt. Airy (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State County
City or town (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jessie F. Gartrell

3.(b) Social Security Number

4. Sex: M
5. Color or race: white
6.(a) Single, married, widowed, or divorced: widower
6.(b) Name of husband or wife: Lloyd Gartrell
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Aug. 27. 1856
8. AGE: Years 90 | Months 5 | Days 22 | If less than one day ..... hrs. ..... min.
9. Birthplace: Frederick Co. (Town, county, and state)
10. Usual occupation: Labor
11. Industry or business
FATHER 12. Name: unknown
FATHER 13. Birthplace: unknown
MOTHER 14. Maiden name: unknown
MOTHER 15. Birthplace: unknown
16. Informant: Cora Seabrent
Address 3 East west St. Baltimore
17. Burial (Burial, cremation, or removal, Which?) Date thereof Feb. 20 1946 (month) (day) (year)
Cemetery or crematory Piney Grove
Location Mt. Airy
16. Funeral director H. M. Snyder
Address Mt. Airy
19. Feb. 19 1946 (Date rec'd by registrar) Jno. D. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1946, at 2:00 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to: Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James V. Howard Deputy Medical Examiner M. D. or other
Address Westminster Md. Date signed 2/18/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

B 1464

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months 21 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 9 months 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 1421 Homestead St. (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: James D. Gray

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Martha Gray
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 31, 1872

8. AGE:	Years	Months	Days	If less than one day
	74	0	18	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Janitor
11. Industry or business:

FATHER
12. Name: John Thomas Gray
13. Birthplace: Harford County, Md.

MOTHER
14. Maiden name: Margaret Ann ?
15. Birthplace: York -

16. Informant: Records of Springfield State Hosp.
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-22-46 (month) (day) (year)
Cemetery or crematory: New Cathedral Cem.
Location: Balto. Md.
18. Funeral director: Williams Cook, Inc.
Address: 1217 St. Paul St.
19 Feb. 19 (Date rec'd by registrar) 19 46 C. Harry Eiker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 19, 19 46, at 12:28P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28, 19 45, to February 19, 19 46 and that I last saw him alive on February 19, 19 46

Immediate cause of death	DURATION
Myocarditis, chronic	
Due to: Mitral vitium plus myocarditis	years
Due to:	
Other conditions: Pyoarthrosis of the right elbow, psychosis with arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. M.D. or other
Address: Sykesville, Md. Date signed: 2-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01463

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 403 East 20th Street, Baltimore
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mary Green

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Jack Green
6.(c) If alive, give age: 57 years
7. Birth date of deceased (mo., day, yr.): 11/29/16

8. AGE: Years	Months	Days	If less than one day
29	2	29	....hrs. ....min.

9. Birthplace: Manchester, Kentucky
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: York
13. Birthplace:
MOTHER 14. Maiden name: Sally Roberts
15. Birthplace: York.
16. Informant: Records of Springfield State Hosp.
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-1-46 (month) (day) (year)
Cemetery or crematory: Springfield Hosp Cem.
Location: Sykesville, Md.
18. Funeral director: C. Harry Weer
Address: Sykesville, Md.
19. March 1 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 28 1946, at 4:10 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 22 1946, to February 28 1946
and that I last saw her alive on February 27 1946

Immediate cause of death	DURATION
Hepatic insufficiency	2 weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Hepatic insufficiency; Ascariasis; Diabetes Mellitus; Bronchopneumonia of lung
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Ruth E. Gilbert M.D.
M. D. or other
Address: Sykesville, Maryland Date signed: 2/28/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

02509

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Union Bridge Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Route 1
(If rural, gives LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert Lee Green Sr.

3.(b) Social Security Number 213-03-1096

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife Edna Marie Green

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 20 - 1892

8. AGE:	Years	Months	Days	If less than one day
	53	2	22	..... hrs. ..... min.

9. Birthplace Frederick County Maryland
(Town, county, and state)

10. Usual occupation Shift Foreman

11. Industry or business Lehigh Portland Cement Co.

FATHER
12. Name William Green
13. Birthplace Maryland

MOTHER
14. Maiden name Annie Carbaugh
15. Birthplace West Penna

16. Informant Mrs. Edna M Green
Address Union Bridge Md Route 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 15 - 1946 (month) (day) (year)

Cemetery or crematory Pipe Creek Cemetery

Location Uniontown Road

18. Funeral director D. D. Hartsler & Sons

Address Union Bridge & New Windsor Md

19. Feb. 14, 1946 (Date rec'd by registrar) C. Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1946 at 6.00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 4 1946, to Feb 12 1946

and that I last saw him alive on Feb 11 1946

Immediate cause of death	DURATION
Uremia, acute	
Due to	
Due to Myocardial Degeneration	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. N. Legg M. D. or other

Address Union Bridge Date signed 2-13-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Hold)

CERTIFICATE OF DEATH

01465 Reg. Dist. No. 70

1. PLACE OF DEATH:
County: Carroll
City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Louisa A. Hahn

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: David H. Hahn
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 24, 1868

8. AGE: Years	Months	Days	If less than one day
77	9	14	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business

FATHER
12. Name: Samuel P. Baumgardner
13. Birthplace: Md.

MOTHER
14. Maiden name: Sarah Dutterer
15. Birthplace: Md.

16. Informant: Mr. David Hahn
Address: Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 10, 1946 (month) (day) (year)
Cemetery or crematory: Lutheran Cemetery
Location: Taneytown, Md.

18. Funeral director: C.O. Fuss & Son
Address: Taneytown, Md.

19. Feb 10, 1946 (Date rec'd by registrar) Ethel M Mehring Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 7 1946, at 7:30p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1941 to Feb. 7, 1946 and that I last saw her alive on Feb. 7, 1946

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration.	7 days
Due to: Generalized arteriosclerosis	10 yrs
Due to:	
Other conditions: Adenocarcinoma of the rectum.	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Adenocarcinoma of the rectum. Date of op. 2.23.44
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: R. S. McVaugh M. D.
M. D. or other
Address: Taneytown, Md. Date signed: 2.8.46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01466 81

★ Reg. Dist. No.

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Juliet Helen Elizabeth Hays

3.(b) Social Security Number: 214-14-6307

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Widowed

6.(b) Name of husband or wife: John Thomas Hays Deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 4 — 1890.

8. AGE:

Years	Months	Days	If less than one day
55	3	14	..... hrs. ..... min.

9. Birthplace: Johnsville Md Frederick Co (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER

12. Name: Samuel Patrick Butler

13. Birthplace: Frederick Co

MOTHER

14. Maiden name: Annie Mary Boyer

15. Birthplace: Frederick Co

16. Informant: Roman Hays Smith

Address: Union Bridge Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2 21 46 (month) (day) (year)

Cemetery or crematory: M. Elco

Location: Near New Windsor

18. Funeral director: Raymond R. Wright

Address: Union Bridge Md

19. Feb 20 1946 (Date rec'd by registrar) Leslie L. Hobbs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 20 1946, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 6 1945 to Feb 20 1946 and that I last saw h alive on Feb 20 1946

Immediate cause of death	DURATION
Intestinal obstruction	4-5 d.
Due to Carcinoma of sigmoid colon	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: as above

Date of op. April, 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E. L. Seigman M. D. or other

Address: Union Bridge, Md. Date signed 2/20/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH 01467

164C

1. PLACE OF DEATH

County Carroll Registration Dist. No. 75

Village or City Millers No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residance in city or town where death occurred 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Lassie G. Harper

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Carrie Harper (52)

6. DATE OF BIRTH (month, day, and year) June 14 1884

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	7	29	

OCCUPATION

8. Trade, profession, or particular kind of work dona, as SPINNER, SAWYER, BOOKKEEPER, etc. Farmer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Data daceased last worked at this occupation (month and yaar)

11. Total tima (years) spent in this occupation

12. BIRTHPLACE (city or town) Pendleton Co. W. Va.
(Stata or country)

FATHER

13. NAME Simon Harper

14. BIRTHPLACE (city or town) Pendleton Co. W. Va.
(State or country)

MOTHER

15. MAIDEN NAME Alice

16. BIRTHPLACE (city or town) Unknown
(Stata or country)

17. INFORMANT Mrs. Carrie Harper Wife
(Address) Millers Md

18. BURIAL, CREMATION, OR REMOVAL
Place Manchester Md Date 2-16, 1946

19. UNDERTAKER Jacob Wrinkle Sons
(Address) Manchester Md.

20. FILED Feb. 15, 1946 Mrs. M. P. S. Denner
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH February (Month) 13 (Day) 1946 (Year)

22. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19

I last saw h aliva on , ~~19~~; death is said to have occurred on the date stated above, at 7:30 m.

Tha **PRINCIPAL CAUSE OF DEATH** and related causes of Importanca were as follows:

	Date of onset
Bullet Wound of Skull & Brain	2/13/46
Other **Contributory Causes** of Importanca: Depression	3 yrs.

Name of operation Date of

What test confirmed diagnosis? Was thera an autopsy? No

23. If death was due to extarnal causes (VIOLENCE) fill in also tha following:

Accident, suicida, or homicide Suicide Date of injury 2-13, 1946

Where did injury occur? Home
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury Shot self with 22 Rifle

Nature of injury Penetrating wound (Bullet) of forehead

24. Was disaase or injury in any way related to occupation of deceased? No

If so, specify

(Signed) W. C. Partenheimer M. D.

(Address) Hampstead Acting County Health Officer Carroll Co.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requiring U. S. No. 1

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0 1468

Reg. Diat. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two 8 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 7 mos 15 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For oewboro infuots give resideoce of mother)

State: Md. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give oearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Catherine Feuerman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W widowed

6.(b) Name of husband or wife: John Feuerman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar 4th 1859

8. AGE: Years 86 | Months 11 | Days 15 | If less than one day: hrs. min.

9. Birthplace: Baltimore
(Town, coooty, and state)

10. Usual occupation: housework

11. Industry or business:

FATHER 12. Name: Jacob Langreker

13. Birthplace: md

MOTHER 14. Maiden name: Caroline Ritter

15. Birthplace: md

16. Informant: Mrs Hannah Roach

Address: 301 South East Ave Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-27-46 (month) (day) (year)

Cemetery or crsmatory: Oak Lawn Cem.

Location: Eastern Ave

18. Funeral director: John C. Miller Inc

Address: 243 E. Lanvale St

19. 2-25 1946 (Date rec'd by registrar) Registror

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 24th 1946, at 10-50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6th 1945 to Sept 24 1946

and that I last saw her alive on Sept 24th 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 da
Due to	
Due to Cerebral Arterio Sclerosis	2
Other conditions Chr. Myocarditis	2

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause te which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (whsre?):

Means of injury: Injured at work?

23. SIGNATURE: W. J. Gaston M.D. M. D. or other

Address: Sykesville Md Date signed: 9/24/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01469 74

Reg. Diat. No.

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 118 West Lee Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Katherine Lillian Hopkins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Melvin Paul Hopkins

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 4/12/09

8. AGE: Years	Months	Days	If less than one day
36	10	9	____ hrs. ____ min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Inspector

11. Industry or business: Defense industry

FATHER 12. Name: Timothy R. Kearns

13. Birthplace: ?

MOTHER 14. Maiden name: Catherine Leon

15. Birthplace: ?

16. Informant: Records of Springfield Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?): Burial Date thereof: Feb. 25-46 (month) (day) (year)

Cemetery or crematory: Holy Cross Cem.

Location: Balto. Md.

18. Funeral director: Fred A. Krause & Son

Address: 1216 S. Charles St.

19. Feb. 22 19 46 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 21 19 46 at 8:25 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/24/46 19 ____ to 2/21 19 46 and that I last saw h er alive on 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yrs.
Due to	
Due to	
Other conditions: Schizophrenia	2 months

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: [illegible] H. Eichert M.D.
M. D. or other

Address: S.S. Hospital, Sykesville, Md. Date signed 2-21-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01479

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months, 22 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1638 Delano Court
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: BESSIE AGNES JENNINGS

3.(b) Social Security Number: 219-16-9803

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 2, 1910

8. AGE: Years	Months	Days	If less than one day
35	3	24	hrs. min.

9. Birthplace: Woodsdale, N.C.
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business
FATHER 12. Name: John Royster
13. Birthplace: North Carolina
MOTHER 14. Maiden name: Narcisses Johnson
15. Birthplace: North Carolina
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 3-3-46
(month) (day) (year)
Cemetery or crematory:
Location: Roxboro - N. C.
18. Funeral director: Charles R. Law
Address: 802 Madison Ave.
19. Feb. 26, 1946
(Date rec'd by registrar)
Albert C. Swankhaus
Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 26, 1946 at 11:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4, 1945 to Feb. 26, 1946 and that I last saw her alive on Feb. 26, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 19 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 2-26-46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)-(a)

CERTIFICATE OF DEATH

01471

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
County Home

How long in hospital or institution? 6 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Balto. Co.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Jones

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
about 65			hrs. min.

9. Birthplace Balto Co. Md.
(Town, county, and state)

10. Usual occupation Worker on farm

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden name "

15. Birthplace "

16. Informant Geo. V. Bankert, Steward,

Address Rural Westminster, Md. Box 167

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 20 1946 (month) (day) (year)

Cemetery or crematory County Home Cemetery

Location Westminster, Md.

18. Funeral director H. Bankard & Son

Address Westminster, Md.

19. 2/19 (Date rec'd by registrar) 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18- 1946 at 10½ A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1946, to Feb 18 1946 and that I last saw him alive on 2-17- 1946

Immediate cause of death	DURATION
Chronic Interstitial nephritis & arteriosclerosis	15 yrs (I)
Due to	
Due to	
Other conditions Uremia	7 days

(Include pregnancy within 3 months of death)

Major findings of operations X Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide X Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Shotz M. D. or other

Address Westminster Date signed 2-18-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

01472

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:

County Carroll Co.

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Most of her life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4 Ward Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME EMMA GRACE KERN

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife Frank X. KERN

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1874

8. AGE:	Years	Months	Days	If less than one day
	71	1	16	..... hrs. ..... min.

9. Birthplace Near Westminster Carroll Co.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name Elizabeth Breitenzer

15. Birthplace Carroll Co. Md.

16. Informant Edwin R. Kern

Address 152 Penna. Ave Westminster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 14 46 (month) (day) (year)

Cemetery or crematory Westminster Cemetery

Location Westminster Md.

18. Funeral director J. E. Myers Jr.

Address Westminster Md.

19. 2/2 46 H. Woodward (Date rec'd by registrar) 19.... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1946 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2 1946 to Feb 11 1946 and that I last saw her alive on Feb 10 1946

Immediate cause of death	DURATION
Pneumonia	10 da.
Bronchial	
Due to Hypertension myocardial degeneration with Edema	2 yrs
Due to Obesity & Nephritis	
Other conditions Chronic interstitial nephritis, duration several years. Cancer (Sent)	over a

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other

Address Westminster Md. Date signed 2/12/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-L)

CERTIFICATE OF DEATH

01473

Reg. Diat. No. 24

FILM No. 100 MAR 4 - 1946

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Edward Manger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah Jane Brown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6/14/1869

8. AGE: Years	Months	Days	If less than one day
~~72~~ 76	8	6	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER 12. Name: George Manger

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Amandis Stansborough

MOTHER 15. Birthplace: Maryland

16. Informant: Records of Springfield State Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 23 - 1946 (month) (day) (year)

Cemetery or crematory: Krider's cemetery

Location: Westminster, Md.

18. Funeral director: H. Bankard & Son

Address: Westminster, Md.

19. Feb. 21 1946 (Date rec'd by registrar) C. Haines Ward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 20 1946, at 4:45 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/16/ 1946, to 2/20 1946

and that I last saw him alive on 2/20/ 1946

Immediate cause of death: Myocarditis	DURATION
Due to: generalized arteriosclerosis	
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	6 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: Cerebral infarct; pneumonia, acute; thrombosis of basilar veins; [illegible]

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Arnold V. Eichert, M.D.
M. D. or other

Address: S. H. Hosp. Sykesville, Md. Date signed 2-20-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (837)

CERTIFICATE OF DEATH

01474 74

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yr., 2 mo., 27 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 5 yr., 2 mo., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Unk—

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Harry Martin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 22, 1884

8. AGE: Years	Months	Days	If less than one day
61	4	2	..... hrs. ..... min.

9. Birthplace: Middleburg, Pennsylvania (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business

FATHER — 12. Name: Unk—

13. Birthplace

MOTHER — 14. Maiden name: Unk—

15. Birthplace

16. Informant: Springfield State Hosp. records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-27-46 (month) (day) (year)

Cemetery or crematory: State Line Cem.

Location: Franklin Co., Pa.

18. Funeral director: R. E. Minnich

Address: Greencastle Pa

19. Feb 25 1946 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 24 1946, at 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943, to Feb. 24 1946

and that I last saw him alive on February 24 1946

Immediate cause of death	DURATION
Cerebral thrombosis	3 days
Due to	
Due to	
Other conditions: Post-traumatic psychosis	7 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May M.D.

M. D. or other

Address: Springfield State Hospital Sykesville, Md. Date signed 2-25-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4-2)

CERTIFICATE OF DEATH

01475

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route 4
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Clara A. Mathias

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Henry R. Mathias
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 23, 1865

8. AGE: Years	Months	Days	If less than one day
80	2	17	hrs. min.

9. Birthplace: Carroll County, Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: Joseph Lippy
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rebecca Angel
15. Birthplace: Maryland

16. Informant: Harry J. Mathias
Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/12/46 (month) (day) (year)
Cemetery or crematory: Leister's Cemetery
Location: near Westminster, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 2/14/46 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 9 19 46, at 9:45p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 25 19 45 to Feb. 9th 19 46
and that I last saw h[illegible] alive on Feb. 9th 19 46

Immediate cause of death: Carcinoma of Intestines — DURATION: 1 yr
Due to:
Due to:
Other conditions: Ascites (Abdominal)
(Include pregnancy within 3 months of death)

Major findings of operation: Carcinoma of Intestines
Date of op. Nov. 1, 45
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. L. Woodward M. D. or other
Address: Westminster Date signed: 2/11/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

01476

Reg. Dist. No. 77

1. PLACE OF DEATH:

County: Carroll

City or town: Greenmount, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Greenmount, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME: ANNIE Miller

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: George Miller

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 28, 1851

8. AGE: Years: 94 | Months: 1 | Days: 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: —

FATHER
12. Name: unknown
13. Birthplace: Germany

MOTHER
14. Maiden name: unknown
15. Birthplace: Germany

16. Informant: Geo. Miller (Son)

Address: Greenmount Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/15/46 (month) (day) (year)

Cemetery or crematory: Miller's Cemetery

Location: Carroll Co. Maryland

18. Funeral director: Jacob Winkelhorn

Address: Manchester, Maryland

19. Feb 13 1946 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 12 1946, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 1938, to February 12 1946 and that I last saw her alive on February 12 1946

	DURATION
Immediate cause of death: Fracture Left Femur.	8 Days
Due to: Fall.	
Due to:	
Other conditions: Generalized arterio-sclerosis and Chronic Myocarditis. (Include pregnancy within 3 months of death)	

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Feb 4, 1946

Where did injury occur? Greenmount (City or town) Carroll (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Slipped on Floor. Injured at work? —

23. SIGNATURE: Jas. E. Buxton M.D.
M. D. or other

Address: Hampstead Md. Date signed: 2-12-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01477

Reg. Diat. No. 75

1. PLACE OF DEATH:
County: Carroll. Myers Dist.
City or town: Rural Westminster R#3
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Carroll.
City or town: Rural.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: West Minster R#3
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Henrietta S. Mummert

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	M.

6.(b) Name of husband or wife: Henry R. Mummert
6.(c) If alive, give age: 72 years
7. Birth date of deceased (mo., day, yr.): April 5 1872

8. AGE:

Years	Months	Days	If less than one day
73	10	21	hrs. min.

9. Birthplace: Carroll County Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Hezekiah Jones
13. Birthplace: Carroll County Md.

MOTHER
14. Maiden name: Amanda Wenty
15. Birthplace: Carroll County Md.

16. Informant: Harry E. Mummert
Address: Reisterstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 1 1946 (month) (day) (year)
Cemetery or crematory: St. Bartholmews
Location: Hanover Pa RD#1 York County
18. Funeral director: W. A. Feaser
Address: Hanover Pa.

19. Feb 28 1946 (Date rec'd by registrar) Mrs. W. R. S. Demmer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 26 1946 at 12:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1939 to Feb 26 1946 and that I last saw h.e.r. alive on Feb 25 1946

Immediate cause of death	DURATION
Terminal Bronchopneumonia	1-2 days.
Due to	
Due to	
Other conditions: Generalized Arteriosclerosis	2 years.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Carroll A. Gray M.D.
M. D. or other
Address: Hanover Pa. Date signed: 2-26-46

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (136)

CERTIFICATE OF DEATH

61478

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 136 N. Jonathan St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: ELMER MURRAY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 31, 1898

8. AGE: Years	Months	Days	If less than one day
47	8	9	hrs. min.

9. Birthplace: Frederick County, Md.
(Town, county, and state)

10. Usual occupation: Shoe Shiner

11. Industry or business

FATHER — 12. Name: Unknown
13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-13-46 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.

18. Funeral director: Wm H Downey
Address: 291 Frederick St. Hagerstown Md.

19. Feb. 10, 1946 (Date rec'd by registrar) Albert R. Swan Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 10, 1946 at 2:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 8, 1946 to February 10, 1946 and that I last saw him alive on February 10, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Address: Henryton, Maryland Date signed 2-10-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

61479

Reg. Dist. No. 70

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taneytown
(If ontside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Fannie R. Myers

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife William G. Myers

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 16, 1869

8. AGE: Years	Months	Days	If less than one day
76	8	10	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Samuel Harman

13. Birthplace Md.

MOTHER 14. Maiden name Frances Taney

15. Birthplace Md.

16. Informant Mr. T.O. Brown

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 1, 1946 (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Taneytown, Md.

18. Funeral director C.O. Fuss & Son

Address Taneytown, Md.

19. Feb 28 1946 Ethel M Mehring Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1946 at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 21 1946 to Feb. 26 1946 and that I last saw h.e.r. alive on Feb. 26 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	5 days
Due to: Cerebral Arteriosclerosis and Hypertension	15 yrs.
Due to:	
Other conditions: Generalized Arteriosclerosis; Partial Paralysis due to old Cerebral Hemorrhage (Include pregnancy within 3 months of death)	15 yrs. 3 yrs.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M.D.
M. D. or other

Address Taneytown, Md. Date signed 2/28/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

(1148) 76

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Route 1, Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 min.

Hospital, Institution, or street address where death occurred:

Springfield.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3402 Seneca St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mary E. Naill

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	widowed

6.(b) Name of husband or wife: Orville J. Naill

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): February 10, 1888

8. AGE: Years	Months	Days	If less than one day
58			...hrs. ...min.

9. Birthplace: Maryland. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: August Shane

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Lucie Filz

MOTHER — 15. Birthplace: Maryland

16. Informant: Jesse Naill

Address: 3402 Seneca St. Balto.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-26-46 (month) (day) (year)

Cemetery or crematory: Sand Ridge

Location: Reisterstown Md

18. Funeral director: Edward L. Donovan

Address: 3617 Chestnut Ave.

19. 2/25 46 (Date rec'd by registrar) 19... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 22 19 46, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: James T. Monk Deputy Medical Examiner

M. D. or other

Address: Westminster Md Date signed 2/22/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BE)

CERTIFICATE OF DEATH

(1481 74

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months, 26 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Caroline

City or town: Ridgely

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: HOWARD RANDOLPH NICHOLS

3.(b) Social Security Number: 222-09-6533

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): September 17, 1909

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
36	4	25		

9. Birthplace: Ridgely, Md. (Town, county, and state)

10. Usual occupation: Farm Worker

11. Industry or business: On farm

FATHER — 12. Name: James Nichols

FATHER — 13. Birthplace: Hillsboro, Md.

MOTHER — 14. Maiden name: Lottie Bedford

MOTHER — 15. Birthplace: Baltimore, Md.

16. Informant: Reuben Hoffman, M. D.

Address: Henrhton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/13/46 (month) (day) (year)

Cemetery or crematory: Hillsboro

Location: Hillsboro, Md.

18. Funeral director: Raymond B. Rawlings

Address: Greensboro Md.

19. 2/11/46 (Date rec'd by registrar) 19 Albert R. Trunkham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 11 19 46, at 2.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16, 19 45, to Feb. 11 19 46

and that I last saw him alive on February 11, 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other

Address: Henryton, Md. Date signed 2/11/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1860

CERTIFICATE OF DEATH

01482

Reg. Dist. No. 71

1. PLACE OF DEATH:

County: Carroll

City or town: Union Town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Town

(If outside city or town limits, write RURAL and give nearest town)

Street No.: West minister. Md

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Martha E. Nicodemus

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Isaac C. Nicodemus deceased

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 31, 1856

8. AGE: Years	Months	Days	If less than one day
89	5	11	____ hrs. ____ min.

9. Birthplace: Frederick Co. Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Jeremiah Keck

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Barbara Yingling

15. Birthplace: Maryland

16. Informant: Mrs. J. S. Burall

Address: Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-14-46 (month) (day) (year)

Cemetery or crematory: Linganore

Location: Winnville Frederick Co. Md.

18. Funeral director: C. W. Waltz

Address: Winfield, Md.

19. Rec'd. 14, 1946 (Date rec'd by registrar) Margaret R. Engler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 12, 1946 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 21 - 1946, to Feb 12 1946

and that I last saw h.. alive on Feb 11 - 46 1946

Immediate cause of death	DURATION
Hypostatic (acute)	
Hypostatic (Chr.)	
Due to:	
Due to:	
Other conditions: Fractured L. femur	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ____ Injured at work?

23. SIGNATURE: W. C. Jamison M.D.

M. D. or other

Address: Westminster Md. Date signed: 2-14-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

01483

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County Carroll

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 1 mo 4 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs 1 mo 4 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Harford Co.

City or town Forest Hill (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Georgie Geiger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If wife, give age ... years

7. Birth date of deceased (mo., day, yr.) Nov 7th 1863

8. AGE: Years 82 | Months 3 | Days 20 | If less than one day ... hrs. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation housework at home

11. Industry or business

FATHER 12. Name Samuel Geiger

13. Birthplace Md

MOTHER 14. Maiden name Georgiana Curley

15. Birthplace Md

16. Informant Mrs Frank Eby

Address Sykesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-2-46 (month) (day) (year)

Cemetery or crematory Old Centre Cemetery

Location Forest Hill, Harford Co., Md.

18. Funeral director C. Harry Elsee

Address Sykesville, Md.

19. Mar. 1 (Date rec'd by registrar) 1946 C. Harry Elsee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28th 1946 at 4a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23 1944 to Feb 28 1946 and that I last saw h alive on Feb 28th 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	4da
Due to Cerebral Arterio Sclerosis	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury Injured at work?

23. SIGNATURE W. J. Gaston M.D. M. D. or other

Address Sykesville Md. Date signed 2/25/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

01484

Reg. Dist. No. 74

FILM No. 100 FEB 26 1946

1. PLACE OF DEATH:
County Carroll
City or town Manchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Carroll
City or town Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Samuel S. Peltzer

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Alice Blanche Peltzer
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21 1871

8. AGE: Years	Months	Days	If less than one day
74 - 7 - 5	8	23	hrs. min.

9. Birthplace Balto Co.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Francis Peltzer
13. Birthplace Balto Co.
MOTHER 14. Maiden name Elizabeth Moar
15. Birthplace Germany
16. Informant Mrs Alice Blanche Peltzer
Address Manchester
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 15-46 (month) (day) (year)
Cemetery or crematory St Johns
Location Balto Co
18. Funeral director J.F. Elene & Sons
Address Westminster, Md.
19. Feb. 13 1946 Mrs W.G. Denner Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13, 1946 at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10 1945, to Feb. 13 1946 and that I last saw h... alive on Feb. 13, 1946

Immediate cause of death	DURATION
Obstruction Lymphoid Tenkaceptic	2
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Jos. E. Buck M. D.
M. D. or other
Address Hampstead Md Date signed 2/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01485

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 25 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1009 W. Saratoga St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ROSALIE RAWLS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 11, 1928

8. AGE: Years	Months	Days	If less than one day
17	3	6	hrs. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business:
FATHER 12. Name: Robert Rawls
FATHER 13. Birthplace: Unknown
MOTHER 14. Maiden name: Ella Scott
MOTHER 15. Birthplace: Baltimore, Md.
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. Buried (Burial, cremation, or removal. Which?) Date thereof 2/21/46 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location:
16. Funeral director: [illegible]
Address: 32[illegible]
19. Feb. 17, 1946 (Date rec'd by registrar) [illegible] Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 17, 1946, at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 22, 1945 to Feb. 17, 1946 and that I last saw her alive on Feb. 17, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 2-17-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01486

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 562 St. Mary's St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: ELLIS RECTOR

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 2, 1893

8. AGE: Years	Months	Days	If less than one day
53	0	14	hrs. min.

9. Birthplace: Warrington, Va. (Town, county, and state)

10. Usual occupation: Kitchen Helper

11. Industry or business:

FATHER — 12. Name: James Rector; 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Rachel King; 15. Birthplace: Virginia

16. Informant: Reuben Hoffman, M. D.

Address: Henryton, Md.

17. Shipped (Burial, cremation, or removal. Which?) Date thereof 2/21/46 (month) (day) (year)

Cemetery or crematory: ?

Location: Warrington, Va.

18. Funeral director: Adolphus Halstead

Address: 918 Druid Hill Ave

19. 2/16 (Date rec'd by registrar) 19 46 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb., 16 19 46 at 6.55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan., 28 19 46 to Feb., 16, 19 46 and that I last saw him alive on Feb., 16, 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Address: Henryton, Md. Date signed 2/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01487

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos. 18 days.
Hospital, institution, or street address where death occurred:
Springfield State Hospital.
How long in hospital or institution? 2 mos. 18 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: -----
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3440 Mondawmin Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: CHARLES H. REHLING

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Rose H. Meyer
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): October 1, 1886

8. AGE: Years	Months	Days	If less than one day
59	4	1	....hrs. ....min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Printer
11. Industry or business: Own print shop

FATHER
12. Name: Henry C. Rehling
13. Birthplace: Baltimore Md

MOTHER
14. Maiden name: Anne Murray Lampe
15. Birthplace: Frederick, Md.

16. Informant: Hoppital records.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 6, 1946 (month) (day) (year)
Cemetery or crematory: Western Cemetery
Location: Balto. Md.
18. Funeral director: L. Howard Strong
Address: Northwest & Hilton Sts.
19. Feb. 3 1946 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 2 1946, at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15, 1945 to Feb. 2 1946 and that I last saw him alive on Feb. 2 1946

Immediate cause of death	DURATION
Broncho-pneumonia (Terminal)	1 day
Due to: Bronchiectasis	known 2 mos.
Due to:	
Other conditions: Psychosis (nature undetermined)	3 years

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Arnold K. Eichert M.D. (M. D. or other)
Address: S.S. Hosp. Sykesville, Md. Date signed 2/3/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

01488

1. PLACE OF DEATH

County Carroll — Registration Dist. No. 71

Village or City Westminster — No. R.D. 7 — St., — Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U.S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Margaret E. Reifsnyder — If U. S. Veteran, specify WAR

(a) Residence: No. Westminster R.D. 7 St., Ward.

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Miles S. Reifsnyder

6. DATE OF BIRTH (month, day, and year) Feb. 26, 1903

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42	11	10	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. None

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Jonestown (State or country) Penna

FATHER

13. NAME William Edris

14. BIRTHPLACE (city or town) (State or country) Penna

MOTHER

15. MAIDEN NAME Sarah Shuey

16. BIRTHPLACE (city or town) (State or country) Penna

17. INFORMANT Miles S. Reifsnyder (Address) Westminster, Md

18. BURIAL, CREMATION, OR REMOVAL Place Baust Cemetery Date Feb. 8, 1946

19. UNDERTAKER J. Francis Rugg (Address) Westminster, Md

20. FILED Feb. 6, 1946 Margaret R. Engler Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb. 6, 1946 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from May, 1937 to Feb. 5, 1946

I last saw h[illegible] alive on Feb. 4, 1946; death is said to have occurred on the date stated above, at 3:15 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Carcinoma (Intestines)	
Carcinoma (with Jaundice)	1½ Y.
Carcinoma (Liver)	

Other Contributory Causes of importance:

Name of operation — Date of

Whether confirmed diagnosis? — Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of injury, 19

Where did injury occur? None (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury None

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No.

If so, specify

(Signed) W. E. Schmidt M. D.

(Address) Westminster, Md

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a **clerk.**

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47d)

CERTIFICATE OF DEATH

01489 76
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 65 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 117 Liberty St. Ext.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ella G. Rickell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Thomas N. Rickell
6.(c) If alive, give age: 74 years
7. Birth date of deceased (mo., day, yr.): August 14, 1877

8. AGE: Years	Months	Days	If less than one day
68	6	4	hrs. min.

9. Birthplace: Hancock, Md. (Town, county, and state)
10. Usual occupation: none
11. Industry or business
FATHER 12. Name: William H. Stanton
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Nanch H. Harsh
MOTHER 15. Birthplace: Maryland
16. Informant: Mrs. J. Thomas Hoffman
Address: Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/20/46 (month) (day) (year)
Cemetery or crematory: Krider's Cemetery
Location: near Westminster, Md.
18. Funeral director: J. Francis Reese
Address: Westminster, Md.
19. 2/19 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 18 1946, at 3 a. m.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 9th 1946, to Feb. 18th 1946
and that I last saw h.er alive on Feb. 17th 1946

	DURATION
Immediate cause of death: Carcinoma of Lung	about 6 mos
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings of operations: Carcinoma of Lung
Date of op. about Nov. 1945
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. Bellangelea, M.D. M. D. or other
Address: Westminster, Md. Date signed 2-18-46

01490

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: CARROLL

City or town: WESTMINSTER - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

CARROLL COUNTY HOME

How long in hospital or institution? 4 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: RURAL WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: NONE

3. (a) FULL NAME: THOMAS W. RILEY

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife: —

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
ABOUT 94			____ hrs. ____ min.

9. Birthplace: NOT KNOWN (Town, county, and state)

10. Usual occupation: VAGRANT

11. Industry or business

FATHER

12. Name: NOT KNOWN

13. Birthplace: " "

MOTHER

14. Maiden name: " "

15. Birthplace: " "

16. Informant: GEORGE BANKERT

Address: WESTMINSTER, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 2/4/46 (month) (day) (year)

Cemetery or crematory: WESTMINSTER CEM.

Location: " MD.

18. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER, MD.

19. 2/2 (Date rec'd by registrar) 19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: FEB. 2 19 46, at 12 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-30 1946, to 2-2- 1946

and that I last saw h. alive on 2-1-46 19

Immediate cause of death	DURATION
Cardiac Embolism	3 days
Due to: Auric sclerosis	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: N/O Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: N/O Date of

Where did injury occur? N/O (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. J. Stone M. D. or other

Address: Westminster Date signed 2/3/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01491

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yr., 11 mo., 18 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 18 yr., 11 mo., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Hananiah Samuels

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Minnie

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 18, 1874

8. AGE: Years	Months	Days	If less than one day
71	11	19	hrs. min.

9. Birthplace: Wales
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: steel mill

FATHER
12. Name: Morgan Samuels
13. Birthplace: Wales

MOTHER
14. Maiden name: Margaret Thomas
15. Birthplace: Wales

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 9, 1946 (month) (day) (year)

Cemetery or crematory: Oak Lawn Cem.

Location: Balto. Md.

16. Funeral director: Lilly & Zeiler, Inc.

Address: 403 S. Wolfe St.

19. Feb. 7 1946 C. Henry Zeiler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 7, 1946, at 5:50a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1943 to Feb. 7, 1946 and that I last saw him alive on February 6, 1946

Immediate cause of death	DURATION
Chronic myocarditis & myocardial degeneration	2 years
Due to:	
Due to:	
Other conditions: Korsakow's Syndrome	20 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.

Springfield State Hospital M. D. or other

Address: Sykesville, Maryland Date signed: 2-7-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

01492 Reg. Dist. No. 77

1. PLACE OF DEATH:
County Carroll
City or town Hampstead (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Hampstead, (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Frank Schnell

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of ~~husband~~ or wife Rosa B Belt
8.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) April 19-1869

8. AGE: Years	Months	Days	If less than one day
76	10	—	...hrs. ...min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Conrad Schnell
13. Birthplace Germany

MOTHER
14. Maiden name Christina Mueller
15. Birthplace Germany

18. Informant Mrs Frank Schnell
Address Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 21 46 (month) (day) (year)
Cemetery or crematory St Johns Catholic
Location Westminster, Md

18. Funeral director Edw A Tipton
Address Hampstead Md

19. 2/20 (Date rec'd by registrar) 19 46 John S. Hughes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 19 46 at 12:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 19 46 to Feb. 19 19 46 and that I last saw h... alive on Feb. 18 19 46

Immediate cause of death	DURATION
Arteria - Sclerotic heart disease & Congestive failure	3 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Maurice C. Partenfield M. D. or other
Address Hampstead, Md Date signed 2-20-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01493

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs. 8 mos. 19 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 7 yrs. 8 mos. 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 2123 Bolton St. (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Dora Sachs Snyder

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Jacob Snyder
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 1, 1893

8. AGE:	Years	Months	Days	If less than one day
	53	0	19	hrs. min.

9. Birthplace: Latvia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Joseph Sachs
13. Birthplace: Latvia

MOTHER
14. Maiden name: Hannah Sachs
15. Birthplace: Latvia

16. Informant: Records of Springfield State
Address: Hosp., Sykesville, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Feb. 21, 1946 (month) (day) (year)
Cemetery or crematory: Nelson Rochelle
Location: Balto. Md.
18. Funeral director: Jack Lewis, Inc.
Address: 2100 Eutaw Place
19. Feb 20 1946 (Date rec'd by registrar) C. Harry Elseer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 20 1946 at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31 1938, to February 20, 1946 and that I last saw her alive on February 20 1946

	DURATION
Immediate cause of death: Pulmonary tuberculosis	4 months 6 weeks
Due to:	
Due to:	
Other conditions: Schizophrenia, Catatonic Type. (Include pregnancy within 3 months of death)	26 years

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. M. D. or other
Address: Springfield State Hosp. Date signed: 2-20-46

01494

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (20-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 1 mo 2 da

Hospital, institution, or street address (if not in hospital): Springfield State Hospital

How long in hospital or institution? 2 yrs 1 mo 2 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Frederick

City or town: Frederick (If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Alberta Lowe Stine

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): 1921

8. AGE: Years: 25 | Months: | Days: | If less than one day: ... hrs. ... min.

9. Birthplace: Brunswick (Town, county, and state)

10. Usual occupation: housework

11. Industry or business: at home

FATHER — 12. Name: Martin L. Lowe

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Grace Shallenwood

MOTHER — 15. Birthplace: Virginia

16. Informant: Martin L. Lowe

Address: Brunswick Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 18-1946 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Frederick Md.

18. Funeral director: C. E. Cline Flory

Address: Frederick Md

19. Feb. 15 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 14th 1946, at 9-15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11th 1943, to Feb 14 1946 and that I last saw h.. alive on Feb 13th 1946

	DURATION
Immediate cause of death:	
Due to: Syphilis	
Due to: Syphilitic Encephalitis	3 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: W. G. Martin M.D. M.D. or other

Address: Sykesville Md. Date signed 2/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

CERTIFICATE OF DEATH

01495

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Taneytown, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John S. Teeter

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Margaret Roop Teeter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 20, 1883

8. AGE: Years	Months	Days	If less than one day
62	2	21	..... hrs. ..... min.

9. Birthplace: Ill
(Town, county, and state)

10. Usual occupation: Road Contractor & Farmer

11. Industry or business

FATHER 12. Name: John D. Teeter

13. Birthplace: Pa

MOTHER 14. Maiden name: Susie Hershey

15. Birthplace: Pa

16. Informant: Mrs. Margaret Roop Teeter

Address: Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 13, 1946 (month) (day) (year)

Cemetery or crematory: Pipe Creek

Location: Near Uniontown, Md.

16. Funeral director: C. O. FUSS & SON

Address: Taneytown, Md.

19. Feb 12 1946 (Date rec'd by registrar) Ethel M. Metzger Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 10, 1946, at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19, 1945 to Feb. 10, 1946 and that I last saw him alive on Feb. 10, 1946

Immediate cause of death	DURATION
Malnutrition	6 mos.
Due to: Carcinoma of the stomach	1 yr.
Due to:	
Other conditions: Metastases to pancreas, kidney and spleen.	8 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: Inoperable carcinoma of stomach with extensive metastases. Date of op. 7.12.45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. S. McVaugh M. D.
M. D. or other

Address: Taneytown, Md. Date signed: 2.11.46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

01496

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: CARROLL

City or town: AVONDALE NR. WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 YEARS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: AVONDALE — NEAR WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: GEORGE EDWARD TURFLE

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): JUNE 12, 1865

8. AGE:	Years	Months	Days	If less than one day
	80	8	13	..... hrs. ..... min.

9. Birthplace: WESTMINSTER, MD. (Town, county, and state)

10. Usual occupation: FARMER (RETIRED)

11. Industry or business

FATHER — 12. Name: THOMAS TURFLE

13. Birthplace: MD

MOTHER — 14. Maiden name: MARGARET MILLER

15. Birthplace: MD.

16. Informant: MRS. PHILIP S. BEACHAM

Address: AVONDALE, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/1/46 (month) (day) (year)

Cemetery or crematory: WESTMINSTER CEM.

Location: WESTMINSTER, MD.

18. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER, MD.

19. 2/27 (Date rec'd by registrar) 19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: FEBRUARY 27 1946, at 2 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-19 1946, to 2-26 1946

and that I last saw h alive on 2-26 1946

Immediate cause of death	DURATION
Uremic Coma	3 days
Due to: Senility - arteriosclerotic	
Due to:	
Other conditions: Fracture of femur - accidental falls in his bedroom aw.o.c.	8 days

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. B. Billingslea M.D. (M. D. or other)

Address: Westminster, Md. Date signed 2-27-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Diat. No. 1497 76

1. PLACE OF DEATH:
County: Carroll
City or town: Shipley
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Shipley
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. Westminster
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Andrew J. Wagner

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of ~~husband~~ or wife: Sadie R. Wagner deceased
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb. 26, 1870
8. AGE: Years: 75 Months: 11 Days: 14 If less than one day: hrs. min.
9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: Unknown
13. Birthplace
MOTHER 14. Maiden name: Unknown
15. Birthplace
16. Informant: John E. Wagner
Address: Westminster Md.
17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 2-13-46 (month) (day) (year)
Cemetery or ~~crematory~~: Harmony Grove
Location: East, Carroll Co. Maryland.
18. Funeral director: E. M. Walz
Address: Winfield Md.
19. 2/12/46 (Date rec'd by registrar) 19 Ray Fogle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby 10 1946 at 2 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 31 1946 to Feby 10 1946 and that I last saw h[illegible] alive on Feby 10 1946
Immediate cause of death: Acute Cardiac Dilatation. — DURATION: 9 hrs.
Due to: Bronchio Pneumonia — DURATION: 11 days
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas. R. Fink M. D. or other
Address: Westminster Md. Date signed 2-11-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01498

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 11 mo's., 28 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 703 W. Saratoga St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Beatrice Norning Ward

3.(b) Social Security Number: 219-16-6146

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Ellie Ward
6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): June 22, 1900

8. AGE: Years	Months	Days	If less than one day
45	7	27	....hrs. ....min.

9. Birthplace: Oak City, N. C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: at home

FATHER
12. Name: Ralph Morning
13. Birthplace: Unknown

MOTHER
14. Maiden name: Sarah Staden
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Feb 23 1946 (month) (day) (year)
Cemetery or crematory: Deale State Cemetery
Location: Rocky Mountain, N. C.,
18. Funeral director: Mrs. Katie R. Williams
Address: 322 N. Schroeder St.

19. 2/19 19 46 (Date rec'd by registrar) Albert R. Lowenthal Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 19, 1946 at 11.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 22, 1944 to Feb. 19 1946 and that I last saw her alive on Feb. 19, 1946

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Jan. 1944
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other
Address: Henryton, Md. Date signed: 2/19/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

01499

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 mos - 2 da.
Hospital, Institution, or street address where death occurred: Spring Grove State Hospital
How long in hospital or institution? 10 mos - 12 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2532 E. Biddle St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Katie Kendland

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed

6.(b) Name of husband or wife: unknown
Hermann 6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov 27 1873

8. AGE: Years	Months	Days	If less than one day
72	2	4	....hrs. ....min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Worked
11. Industry or business: Bakery
FATHER 12. Name: — Kiefer
13. Birthplace: Germany
MOTHER 14. Maiden name: Unk
15. Birthplace: Germany
18. Informant: Mrs. Margaret Wathen
Address: 1021 Allingtondale, Balto
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 13, 1946 (month) (day) (year)
Cemetery or crematory: Parkwood Mem.
Location: Balto. Md.
18. Funeral director: William Cook, Inc.
Address: 1217 N. Paul St.
19. Feb. 10 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 9th 1946 at 6-05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7th 1945 to Feb 9th 1946 and that I last saw her alive on Feb 9th 1946

Immediate cause of death	DURATION
Bronchopneumonia	3 da
Due to: Influenza.	2 wks
Due to:	
Other conditions: Chr. Hypertension Arteriosclerosis	?

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W. J. Gaston M.D.
M. D. mother
Address: Sykesville Md. Date signed 2/9/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01500

Reg. Diat. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Rural near Manchester Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural near Manchester Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME E. Alice Wentz

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Philip K Wentz (deceased)
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Mar. 22 - 1853

8. AGE: Years	Months	Days	If less than one day
92	10	9	hrs. min.

9. Birthplace: Carroll Co. Maryland (Town, county and state)
10. Usual occupation: House wife
11. Industry or business
FATHER 12. Name: William Resh
13. Birthplace: Carroll Co. Md.
MOTHER 14. Maiden name: Eliza Baumgardner
15. Birthplace: Carroll Co. Md.
16. Informant: Mrs. Harry Ruppe
Address: Hanover, Pa.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-3-46 (month) (day) (year)
Cemetery or crematory: cementry
Location: Greenmount Carroll Co. Md
18. Funeral director: Jacob Wenk's Sons
Address: Manchester. Md.
19. Feb. 7 1946 (Date rec'd by registrar) Mrs. W. R. S Denner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 1 1946, at 5 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 30 1946 to Feb 1 1946
and that I last saw h... alive on Jan 30 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Senile Cardiac Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. D. or other
Address: Hanover Date signed: Feb 1 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 467

01501

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. Main Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Paul Whitehill

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 26 - 1879

8. AGE:	Years	Months	Days	If less than one day
	66	2	11	..... hrs. ..... min.

9. Birthplace Frederick County Maryland (Town, county, and state)

10. Usual occupation Dealer in Livestock

11. Industry or business

FATHER 12. Name John Whitehill

13. Birthplace Maryland

MOTHER 14. Maiden name Susan Barnes

15. Birthplace Maryland

16. Informant Miss Margaret Whitehill

Address Union Bridge Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 10 - 1946 (month) (day) (year)

Cemetery or crematory Longamore Cemetery

Location Uniontown Maryland

18. Funeral director D. D. Hartle & Son

Address Union Bridge & New Windsor Md

19. Feb 8, 1946 (Date rec'd by registrar) Rickman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7, 1946 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 1, 1946 to Feb 7, 1946 and that I last saw h.. alive on Feb 1, 1946

Immediate cause of death	DURATION
Internal Hemorrhage	
Due to Carcinoma of the head of Pancreas	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Swope M.D. M. D. or other

Address Union Bridge Md Date signed Feb 8, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-d

CERTIFICATE OF DEATH

★ 01502

Reg. Dist. No. 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 yrs. 2 mo. 12 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 16 yrs. 2 mo. 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Unknown (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ROSIE WILBERT (WILBURN)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) mo. day, unknown 1894

8. AGE: Years 52 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Garrett County Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER 12. Name: John T. Wilburn

13. Birthplace: Garrett County

MOTHER 14. Maiden name: Marthy Ellen Boyer

15. Birthplace: Garrett County, Md.

16. Informant: Hospital Records

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Feb. 22, 1946 (month) (day) (year)

Cemetery or crematory: Braeside

Location: Garrett Co., Md.

18. Funeral director: C. Harry Klee

Address: Sykesville, Md.

19. Feb 19 1946 (Date rec'd by registrar) C. Harry Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 18, 1946 at 3.25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 11 1946 to Feb. 17 1946 and that I last saw h.. alive on Feb. 17 1946

	DURATION
Immediate cause of death: Chronic myocarditis	5 yrs.
Due to: Generalized arteriosclerosis	5 yrs.
Due to:	
Other conditions: Chronic otitis media, bilateral; Schizophrenia, catatonic (Include pregnancy within 3 months of death)	Unknown; 10 yrs.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Joseph H. Marshall M. D. or other

Address: Springfield State Hospital Date signed 18 Feb. 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P1503

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 4 mos. 23 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 629 Gilbert St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: LESLIE WILKINS

3.(b) Social Security Number: 227-07-0830

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 3, 1918

8. AGE: Years	Months	Days	If less than one day
28	0	17	hrs. min.

9. Birthplace: Wheeling, W. Va.
(Town, county, and state)
10. Usual occupation: Welder
11. Industry or business

FATHER
12. Name: Wesley Wilkins
13. Birthplace: Unknown

MOTHER
14. Maiden name: Martha Jones
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 25, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Auburn Cemetery
Location:
18. Funeral director: Mrs. Katie R. Williams
Address: 322 N. Schroeder St.

19. Feb. 20, 1946 (Date rec'd by registrar) Albert R. Shoemaker Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 20, 1946 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 27, 1943 to Feb. 20, 1946 and that I last saw him alive on Feb. 20, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1943
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed 2-20-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-A)

CERTIFICATE OF DEATH

01504

Reg. Diat. No. 74

1. PLACE OF DEATH:
County CARROLL
City or town SYKESVILLE R. # 1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? LIFE
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County CARROLL
City or town SYKESVILLE # 1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME LAURA VIRGINIA WILLIAMS

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	White	MARRIED

6.(b) Name of husband or wife CARROLL E. WILLIAMS
6.(c) If alive, give age 59 years
7. Birth date of deceased (mo., day, yr.) FEB. 25 - 1890

8. AGE: Years	Months	Days	If less than one day
56	—	—	....hrs. ....min.

9. Birthplace CARROLL COUNTY (Town, county, and state)
10. Usual occupation HOUSE WIFE
11. Industry or business
FATHER 12. Name JOSEPH T. PARRISH
FATHER 13. Birthplace MARYLAND.
MOTHER 14. Maiden name MARY ALICE GORSUCH
MOTHER 15. Birthplace MARYLAND
16. Informant CARROLL E. WILLIAMS
Address SYKESVILLE R # 1
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof FEB. 27 - 1946 (month) (day) (year)
Cemetery or crematory MT. PLEASANT
Location GAMBER MD.
18. Funeral director J. F. Reese
Address WESTMINSTER MD.
19. Feb. 25 1946 (Date rec'd by registrar) C. Harry Zepp Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1946, at 2:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935 19.. to Feb 25 1946
and that I last saw h..er alive on Feb 25 1946

	DURATION
Immediate cause of death general arteriosclerosis	
Due to: Chronic myocarditis	
Due to: Chronic interstitial nephritis	
Due to:	
Other conditions: acute pneumonia of	
(Include pregnancy within 3 months of death)	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. H. Lawson M. D.
M. D. or other
Address Hyattsville Date signed 2/25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

01505

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos. 23 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 3 mos. 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Andrew E. Wilson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/6/73

8. AGE: Years	Months	Days	If less than one day
73	1	17	hrs. min.

9. Birthplace Sykesville, Carroll, Maryland (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Levi Wilson
13. Birthplace Sykesville, Maryland

MOTHER
14. Maiden name Emma Phillips
15. Birthplace Carroll Co., Maryland

16. Informant Record of Springfield State Hospital
Address Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-25-46 (month) (day) (year)
Cemetery or crematory Bethesda
Location E. 1st, Carroll Co. Maryland.

18. Funeral director C.M. Waltz
Address Winfield, Md

19. Feb 25 1946 (Date rec'd by registrar) C. Henry Wells Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/23/ 1946 at 6:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/1/45 to 2/23/46 and that I last saw him alive on 2-23-46

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to	
Due to	
Other conditions Senile Psychosis	5 years

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Arnold H. Eichert M.D. M. D. or other
Address S.S.H. Hosp. Sykesville Md Date signed 2-23-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1506

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 yrs., 10 mos., 28 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 19 yrs., 10 mos., 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Halethorpe
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

John Zimmerer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Elizabeth Zimmerer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 7/1/1881

8. AGE: Years	Months	Days	If less than one day
64	7	26	..... hrs. ..... min.

9. Birthplace: Baltimore City
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Henry Zimmerer
13. Birthplace: Baltimore City

MOTHER
14. Maiden name: Elizabeth Lang
15. Birthplace: Germany

16. Informant: Records of Springfield State Hosp.
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal, Which?) Date thereof 3-2-46 (month) (day) (year)

Cemetery or crematory: Western Cemetery

Location: Balto. Md.

18. Funeral director: William Cook, Inc.

Address: 1217 St Paul St.

19. Feb. 28 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 27 1946, at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to 2/27 1946

and that I last saw him alive on 2/27 1946

Immediate cause of death	DURATION
Chronic Myocarditis	unknown
Due to: Acute Interstitial Pneumonia of Lungs	unknown
Due to:	
Other conditions: Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results? No. Not requested; Coroner's Case

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Louis J. Eckert, M.D.
M. D. or other

Address: Sykesville, Md. Date signed 2/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15